**Discharge Planning Project**

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**Summary of Patient**

Mr. J.D. is a 86 year old male who was brought into the emergency room by EMS on 11/03/13 with an altered mental status and dyspnea. These symptoms had been worsening over the past week and consequently he was brought in. Per EMS, patient was confused, oxygen saturation of 88% on nasal cannula, and blood glucose of 103. According to the daughter, the patient was somewhat disoriented and was having a lot of difficulty with breathing. Despite respiratory treatment at the assisted living facility, symptoms would not resolve. Patient was brought into the ER and transferred to CCU where he was diagnosed with congestive heart failure and renal disease. The patient is a full code and according to doctor’s, the patient’s health is continuing to deteriorate.

**Discharge Diagnosis**

The patient is confused and was still confused, so based off of my assessments, I do not believe that the patient understands why they were hospitalized. The patient’s daughter is the power of attorney and was the one taking all medical decisions for him. The main teaching points specific to the disease processes the patient has been newly diagnosed with are ways to maintain current health. The patient has other co-morbid conditions such as diabetes, hypertension, COPD, and dementia that learning ways to keep a balance to maintain his health.

**Medications**

The new medications Mr. J.D. is receiving through the hospital are antibiotics. Depending on his health status upon discharge, he may or may not have to continue on them. As of now, there are no new medications to reconcile. The patient has been on his medications for a while now so there is an understanding. The daughter understands the new antibiotics as Mr. J.D. is confused.

**Home Assessment**

The patient lives at an assisted living facility. This is the safest living situation as Mr. J.D. is unable to take care of himself and live on his own. The assisted living facilty takes care of medications and food and doctors are there to follow up on the residents of the assisted living facility. The patient is covered through Medicaid and Tricare so there are no financial concerns as of now.

**Follow-Up**

Since the patient will be discharged back to the assisted living facility, there is not a need for home health services or durable medical equipment at this time. Follow up appointments will be take care of at the facility. The patient already has a list of specialists that follow up on him but he should continue to see a cardiologist, nephrologist, and a urologist. Following up with an infectious disease doctor may also be recommended. Since the patient’s health is declining, doctors have met with his daughter to take palliative and supportive care into consideration. Physical therapy and occupational therapy may also be beneficial for the patient. There is not much that can be done for Mr. J.D. besides giving him comfort care. The doctors have explained to the daughter about considering changing Mr. J.D.’s code status to a do not resuscitate.

**Summary**

In order to prevent readmission for this patient, it is important that the patient takes medications on time. Since the patient has dementia, it is also important that there is someone there to help with medications and feedings. Maintaining comfort and a stress free environment will also be recommended. Making sure that his physicians see the patient and all follow up lab work and such is taken care of will also be helpful All in all; the best thing we can provide for this patient is comfort at this time.